MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 04842

Reg. Diat. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Woodbine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Woodbine

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary E. Hood-Beam

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife William Beam

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 - 1866

8. AGE:

Years	Months	Days	If less than one day
81	11	18	hrs. min.

9. Birthplace Westminster, Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Tobias Reindollar

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Annie Martin

15. Birthplace Carroll Co. Md.

16. Informant Mrs Nellie J. Fogle

Address 132 Penn. Ave. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 25: 1948 (month) (day) (year)

Cemetery or crematory Fairview Cemetery

Location Westminster, Md.

18. Funeral director H Bankard Son

Address Westminster, Md.

19. 5/23 1948 (Date rec'd by registrar) C. M. Kerwin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1948 at 1:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1948, to May 23 1948 and that I last saw her alive on May 22 1948

Immediate cause of death	DURATION
General cardiovascular disease with hypostasis & myocarditis	
Due to Senile changes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury, Injured at work?

23. SIGNATURE C. M. Kerwin M.D. M. D. or other

Address Sykesville, Md. Date signed 5/23/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 04843

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred: Baltimore - Hanover Pike, Manchester Md

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Manchester, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore - Hanover Pike,

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME missouri Sterner Stoner Black

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Mr. John Winter Black

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	17	... hrs. ... min.

9. Birthplace: York Co. Pennsylvania (Town, County, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Henry Sterner

13. Birthplace —

MOTHER — 14. Maiden name: Lorene Bang

15. Birthplace —

16. Informant: Mr. John M. Black

Address: Manchester, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5, 25, 48 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: State Church York Co Pa

18. Funeral director: Jacob Wright Sons

Address: Manchester Md

19. May 22 1948 Mrs. W. P. S. Denner

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1948, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-18-48, to 5-21 1948

and that I last saw h.e.r alive on 5-21 1948

Immediate cause of death: Cardio-respiratory failure & acute pulmonary edema — DURATION

Due to: Hypertensive cardio-vascular disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John Hays Rosser M D

M. D. or other

Address: University Hospital Baltimore, Md Date signed 5-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04844

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 4 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 10 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: IONE BLACKISTON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7/2/12

8. AGE: Years	Months	Days	If less than one day
35	10	19	..... hrs. ..... min.

9. Birthplace: Kent County, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Sarah

15. Birthplace: Unknown

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23 1948 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall Kent Co. Maryland

16. Funeral director: Marin & Williams

Address: Chestertown Maryland

19. May 24 1948 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION DST

20. DATE OF DEATH: May 21 19 48, at 4:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17, 19 47 to May 21 19 48

and that I last saw her alive on May 20 19 48

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 1 yr.

Due to:

Due to:

Other conditions: Schizophrenia, paranoid type — 14 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M.D. or other

Address: Sykesville, Maryland Date signed: 5/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

516 ✓ 04845

Reg. Diat. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Louisville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural -- Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Louisville
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GEORGE E. BOONE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Kate P. Boone
6.(c) If alive, give age: 81 years
7. Birth date of deceased (mo., day, yr.): Jan. 18, 1866

8. AGE: Years: 82 | Months: 4 | Days: 13 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: John Henry Boone
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Ann Turnbull
15. Birthplace: North Carolina

16. Informant: Mrs. Kate P .Boone
Address: Sykesville, Md.

17. (Burial, ~~cremation, or removal. Which?~~) Burial
Date thereof: 6-3-48 (month) (day) (year)
Cemetery ~~or crematory~~: Mt. Pleasant
Location: Gamber, Carroll Co. Md.
18. Funeral director: C. M. Waltz
Address: Winfield, Md.

JUN 2 1948 19.....
(Date rec'd by registrar)
Ray Togle
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1948 at 6:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..
and that I last saw h.. in alive on May 31 1948

Immediate cause of death: arteriosclerotic cardiovascular disease Carcinoma of Prostate — DURATION

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W H Lawson M.D.
M. D. or other
Address: Sykesville Date signed: 5/31/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04846

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months 17 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Harry Walter Bosley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Fannie Byerly

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 26, 1871

8. AGE: Years	Months	Days	If less than one day
76	10	12	hrs. min.

9. Birthplace: Baltimore County (Town, county, and state)

10. Usual occupation: Attendant

11. Industry or business: Filling Station (retired)

FATHER

12. Name: Joshua Nelson Bosley

13. Birthplace: Baltimore Co.

MOTHER

14. Maiden name: Sarah Brummel

15. Birthplace: Baltimore County

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10 48 (month) (day) (year)

Cemetery or crematory: Hampstead

Location: Carroll Co Md

18. Funeral director: Edw A Tipton

Address: Hampstead, Md

19. May 9 1948 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1948 19 at 2.25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 1947 19 to May 8 1948 and that I last saw him alive on May 8 1948

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to: Gen'l Arterio-Sclerosis	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. D. Masters M.D. M. D. or other

Address: Sykesville Md Date signed: 5/8/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

04847

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 1 month 3 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or Institution? 5 yrs. 1 month 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County — —

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. — — —
(If rural, give LOCATION)

2.(a) If veteran, name war — — —

3.(a) FULL NAME
BROWN, Annie E. (Media)

3.(b) Social Security Number
705-05-6734

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife — — —

— — — 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 30, 1865

8. AGE: Years	Months	Days	If less than one day
82	5	5	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation book folder

11. Industry or business — —

FATHER 12. Name John N. Brown

13. Birthplace Maryland

MOTHER 14. Maiden name Sophie Baitzell

15. Birthplace Maryland

16. Informant Records of Springfield St. Hospital

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8th. 1948 (month) (day) (year)

Cemetery or crematory Druid Ridge Cemetery

Location Pikesville Md.

18. Funeral director Geo. K. Beyer Jr.

Address 1512 Hollins St., Balto. Md.

19. may 6 19 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 19 48 at 2:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11 19 44 to May 5 19 48 and that I last saw her alive on May 5 19 48

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	more than 5 years
Due to — — —	
Due to — — —	
Other conditions Arteriosclerosis) Senile psychosis) (Include pregnancy within 3 months of death)	6 yrs.

Major findings of operation — — —

Date of op. — — —

Autopsy results — — —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. N. Mastin M.D.
W. N. Mastin, M. D. M. D. or other

Address Sykesville, Maryland Date signed 5/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Evidence for change of age and birthdate shown on: FILM No. G-115 MAY 18 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04848

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 5 months 18 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 1 yr. 5 months 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: — — —
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 3726 Park Heights Avenue (If rural, give LOCATION)
2.(a) If veteran, name war: — — —

3.(a) FULL NAME: Byrne, Christopher Joseph

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	unkn.

6.(b) Name of husband or wife: — — —
6.(c) If alive, give age: — — years

7. Birth date of deceased (mo., day, yr.): December ~~26~~, 1880 ~~24~~, 1873

8. AGE: Years	Months	Days	If less than one day
74~~88~~	4	~~8~~ 10	hrs. min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: landscape gardener
11. Industry or business: — — —

FATHER
12. Name: John Joseph Byrne
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Meaghan
15. Birthplace: Ireland

16. Informant: Records of Springfield St. Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/7/48 (month) (day) (year)
Cemetery or crematory: St. Marys Govans
Location: Homeland Ave.

18. Funeral director: Wm. J. Tickner & Sons
Address: North & Pa. Ave

19. May 6 1948 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1948, at 12:20 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947, to May 3 1948 and that I last saw him alive on May 3 1948

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	more than 5 months
Due to: — — —	
Due to: — — —	
Other conditions: Jaundice	2 weeks
possible cancer of the liver (Include pregnancy within 3 months of death)	unknown

Major findings of operations: — — —
Date of op. — — —
Autopsy results: — — —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: — — — Date of — — —
Where did injury occur? — — — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) — — —
Means of injury — — Injured at work? — — —

23. SIGNATURE: Martin Gross, M. D. M. D. or other
Address: Sykesville, Maryland Date signed: 5/4/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

0484?

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 3 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 331 N. Pearl Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM HENRY CAIN

3.(b) Social Security Number: 379-07-1736

4. Sex: Male

5. Color or race: colored

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Doris Cain

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): May 15, 1912

8. AGE: Years: 36 Months: 0 Days: 4 If less than one day: ...hrs. ...min.

9. Birthplace: Rocky Mountain, N. C. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER 12. Name: Blunt King

13. Birthplace: North Carolina

MOTHER 14. Maiden name: Charlotte Hines

15. Birthplace: North Carolina

16. Informant: Deceased

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23. 1948 (month) (day) (year)

Cemetery or crematory: Mount Auburn Cemetery

Location: Baltimore Co. Maryland

19. Funeral director: Joseph A. Lundy

Address: 66 West Lane St Baltimore Md

19. 5/19/ 19 48 (Date rec'd by registrar) Albert R. Swank Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19, 1948 at 5.50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1948, to May 19, 1948 and that I last saw him alive on May 19, 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	November 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eileen W. Swan, M. D. M. D. or other

Address: Henryton, Md. Date signed 5/19/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830 0485D

Reg. Diat. No. 71

1. PLACE OF DEATH:

County: Carroll

City or town: Uniontown (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Uniontown (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lizzie Edella Carr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Albert Carr.

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): May 10 - 1869

8. AGE: Years 79 | Months — | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Cornelius Tracy

13. Birthplace: Md

MOTHER 14. Maiden name: Sarah Bowman

15. Birthplace: Md

16. Informant: Mr Albert Carr.

Address: Uniontown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30/48 (month) (day) (year)

Cemetery or crematory: Princeton

Location: Balto co. Md

18. Funeral director: Edw C Tipton

Address: Hampstead, Md

19. May 30 1948 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1948 at 10 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1948 to May 27 1948 and that I last saw it alive on May 26 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mssns of injury Injured at work?

23. SIGNATURE: J. N. Legg M. D. or other

Address: Union Bridge Date signed 5/27/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, "no correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

04851

Reg. Dist. No. 76

1. PLACE OF DEATH

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred:

400 E. Main

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 400 E. Main

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Albert Vincent Cover

3.(b) Social Security Number 216-14-3465

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Lucretia Pauline Smith

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 28 - 1875

8. AGE:

Years	Months	Days	If less than one day
72	10	1	hrs. min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Farmer, Ret.

11. Industry or business

FATHER

12. Name Peter H. Cover

13. Birthplace Md.

MOTHER

14. Maiden name Elizabeth Creswell

15. Birthplace Md.

16. Informant Lucretia P. Cover

Address 400 E. Main, Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1, 1948 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Uniontown, Md

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 5/31 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1948, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1 1948, to May 29 1948

and that I last saw him alive on May 28 1948

Immediate cause of death Acute Cardiac Dilatation — DURATION 10 M.

Due to Chronic Myocarditis 6 Mos

and Hypertension 6 mos

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward R Todd MD

M.D. or other

Address Westminster Md Date signed 5-31-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04852

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-46-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs two 22 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yr 7 mos 22 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Lula Mae Crowford.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: William Wallace Crowford

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 25 th 1878

8. AGE:

Years	Months	Days	If less than one day
69	11	6	____ hrs. ____ min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housekeeper.

11. Industry or business: at home

FATHER
12. Name: John Eyerly
13. Birthplace: Md.

MOTHER
14. Maiden name: Susan Wolfe
15. Birthplace: Md

16. Informant: Mrs Joseph Potts
Address: 149 Spruce St Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10 48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: C. L. Surman Co. Ralph Myers

Address: Hagerstown Md.

19. May 9 1948 (Date rec'd by registrar) Harry Keer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7th 1948 at 10 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 14 1944 to May 7th 1948 and that I last saw h alive on May 7th 1948

Immediate cause of death	DURATION
Coronary Occlusion	—
Due to: Cerebral Arterio Sclerosis	4 yrs
Due to: Hypertension	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: W. F. Gaston M.D. M. D. or other

Address: Sykesville Md Date signed 5-7-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

04853

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs. Formerly Carroll Co.,
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Penna. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Theodore Cummings

3.(b) Social Security Number 214-16-1663

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Annie K. Cummings
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1866

8. AGE:

Years	Months	Days	If less than one day
81	8	3	hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation
11. Industry or business School Janitor

FATHER
12. Name Jacob Cummings
13. Birthplace Md

MOTHER
14. Maiden name Matilda Powell
15. Birthplace Md

16. Informant Jesse P. Cummings
Address Finksburg, Md. R#1

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12, 1948. (month) (day) (year)
Cemetery or crematory Baust
Location Tyrone, Md.

18. Funeral director C. O. FUSS & SON
Address Taneytown, Md.

19. 5/10/48 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1948 at 1-15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1948 to May 9. 1948
and that I last saw h[illegible] alive on May 8th 1948
Immediate cause of death Acute Cardiac Dilatation — Duration 8 hours
Due to Acute Interstitial Nephritis. — Duration 10 days
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operation — Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Chas. R. Fouty M.D. (M.D. or other)
Address Westminster Md. Date signed 5-9-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

82a 04854

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 5 mo 7 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr 4 mo 7 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Frederick

City or town: Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret Amelia Dasmuth

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: George Dasmuth

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 12th 1870

8. AGE: Years 77 Months 11 Days 27 If less than one day ____ hrs. ____ min.

9. Birthplace: Frederick (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

MOTHER FATHER

12. Name: Cornelius Black

13. Birthplace: Frederick

MOTHER

14. Maiden name: Amelia Young

15. Birthplace: Frederick

16. Informant: Lester D. Dasmuth

Address: Emmitsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11, 1948 (month) (day) (year)

Cemetery or crematory: United Brethren Cem

Location: Thurmont, Md.

18. Funeral director: M R Etzlerson & Son

Address: Frederick, Md.

19. May 9 1948 (Date rec'd by registrar) C Harry Keefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8th 1948 at 6-15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8th 1947 to May 8th 1948 and that I last saw h[illegible] alive on May 8th 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 wk
Due to: Sent Arterio Sclerosis	5 yrs
Due to:	
Other conditions: Hypertension	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: J J Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed 5/8/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 04855

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 3 years 7 months 13 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 N. Bond Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lemuel Dean

3.(b) Social Security Number: 220-01-1905

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Thelma Dean

6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): July 20, 1920

8. AGE: Years	Months	Days	If less than one day
27	9	22	...hrs. ...min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Raymond Dean

13. Birthplace: Cambridge, Md.

MOTHER — 14. Maiden name: Missouri Fletcher

15. Birthplace: Cambridge, Md.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15 1948 (month) (day) (year)

Cemetery or crematory: Old Field Cemetery

Location: Dorchester Co. Md.

18. Funeral director: Robert E. Williams

Address: 515 McElderry St.

19. May 12 19 48 (Date rec'd by registrar) Albert R. Trankham Local Deputy Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: May 12 19 48 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 29 19 44 to May 12 19 48 and that I last saw him alive on May 12 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: Eileen Hoffman M. D.
M. D. or other

Address: Henryton, Md. Date signed: 5/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 04856

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 651 W. Lexington Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Reginald Bryan Dillon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): September 7, 1890

8. AGE: Years	Months	Days	If less than one day
57	8	3	... hrs. ... min.

9. Birthplace: Granger, North Carolina
(Town, county, and state)

10. Usual occupation: Candy Vendor

11. Industry or business:

FATHER
12. Name: Henry Edward Dillon
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Celeste Stanton
15. Birthplace: North Carolina

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15, 1948 (month) (day) (year)
Cemetery or crematory: Springfield Hospital Cem.
Location: Sykesville, Md.

18. Funeral director: C. Harry Heer
Address: Sykesville, Md.

19. May 15 1948 (Date rec'd by registrar) C. Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1948, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1948 to May 10 1948 and that I last saw him alive on May 10 1948

Immediate cause of death	DURATION
Coronary occlusion	1 hour
Due to: Arteriosclerosis	
Due to:	
Other conditions: Psychosis probably due to alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Coronary occlusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Ilse Kamm, M.D. Ilse Kamm M.D.
M.D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 5-15-48

Evidence for change of age and birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G. 115 MAY 18 1948

CERTIFICATE OF DEATH

Reg. Diat. No. 14857

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs. 3 months 6 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 18 yrs. 3 months 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: - - -

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. - - -
(If rural, give LOCATION)

2.(a) If veteran, name war - - -

3. (a) FULL NAME

Driscoll, Patrick (Patrick Driscoll)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife - - -

- - - 6.(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) March 16, ~~1889~~ 1879 1882

8. AGE: Years	Months	Days	If less than one day
66 69 ~~59~~	1	18	....hrs. ....min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business - - -

FATHER 12. Name: Jeremiah Driscoll

13. Birthplace: Ireland

MOTHER 14. Maiden name: Mary Buttimer, dec.

15. Birthplace: Ireland

16. Informant: Records of Springfield St. Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/7/48 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Edmondson Avenue, Balto: Md.

18. Funeral director: George J. Ruth, Inc.

Address: 1735 Harford Avenue

19. 5/5 (Date rec'd by registrar) 1948 A. H. Hedrick mea Asst Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1948, at 9:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947, to May 3 1948 and that I last saw him alive on May 3 1948

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	1 yr.
Due to - - -	
Due to - - -	
Other conditions: Coronary occlusion	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations - - -

Date of op. - - -

Autopsy results - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Martin Gross M. D.
Martin Gross, M. D. M. D. or other

Address: Sykesville, Maryland Date signed 5/4/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 014887

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Albert Ray Dudderar

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 19 - 1872

8. AGE: Years 75 | Months 5 | Days 26 | If less than one day: hrs. min.

9. Birthplace: Frederick County, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: David S. Dudderar
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Ann Pearre
15. Birthplace: Maryland

16. Informant: Mrs. Thomas Gaither
Address: Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/18/48 (month) (day) (year)
Cemetery or crematory: Sugarow Cemetery
Location: Uniontown, Md.

18. Funeral director: W. H. Hartley & Sons
Address: Union Bridge New Windsor, Md

19. May 16 1948 (Date rec'd by registrar) — Eichman, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1948, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1948, to May 15 1948
and that I last saw h[illegible] alive on May 11 1948

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to: arteriosclerotic Cardio-Vascular disease	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operation: — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Merritt E. Robertson, M. D. or other
Address: New Windsor, Md Date signed: May 15, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

85

04859

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 3 mos 1 day

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 20 yrs 5 mos 1 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Frederick

City or town Emmitsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Merle M Eyler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 25-1910

8. AGE: Years 37 | Months 4 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation not any

11. Industry or business

MOTHER FATHER

12. Name Sam D Eyler

13. Birthplace Md

MOTHER

14. Maiden name Sarah Wetzel

15. Birthplace Md.

16. Informant Martin W C Eyler

Address Emmitsburg Md

17. Burial Date thereof May 6 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Springfield Hospital Cem.

Location Sykesville Md.

18. Funeral director Harry Heer

Address Sykesville Md.

19. May 6 1948 Harry Heer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3d 1948 at 7-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1927 to May 3d 1948

and that I last saw h— alive on May 3d 1948

Immediate cause of death	DURATION
Due to Epilepsy	22 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W J Gaston M D
M. D. or Other

Address Sykesville Md Date signed 5/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 93d

04860

Reg. Diat. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days.

Hospital, Institution, or street address where death occurred: Longview Nursing Home

How long in hospital or institution? 18 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Md (If outside city or town limits, write RURAL and give nearest town)

Street No. East Main St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: M. Katherine Fiscel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 29 - 1878

8. AGE: Years: 70 (?) | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Sam's Creek, New Windsor (Town, county, and state) Carroll Co Md

10. Usual occupation: Retired school Teacher

11. Industry or business:

FATHER

12. Name: Ephraim Fiscel

13. Birthplace: Gettysburg Pa.

MOTHER

14. Maiden name: Matilda Fiscel (?)

15. Birthplace: Gettysburg Pa.

16. Informant: Mrs William S. Foreman 6010 Broadband Rd - Chevy Chase D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1, 48 (month) (day) (year)

Cemetery or crematory: Pipe Creek cemetery

Location: Uniontown, Carroll Co. Md.

18. Funeral director: J. E. Myers Jr.

Address: Westminster Md.

19. May 29 1948 (Date rec'd by registrar) Mrs. M. R. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1948 at 9 55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1948, to May 29 1948 and that I last saw h ew alive on May 28 1948

Immediate cause of death	DURATION
Coronary Thrombosis	5 Days
Due to: Heart Bloc.	?
Due to: Chronic Myocarditis	
Other conditions: Senile Dementia.	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Joseph E Buck M D M. D. or other

Address: Hampstead Md. Date signed 5-29-48

Evidence for change of birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04861

FILM No. G 116 JUN 21 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 81.

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural #1
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Henry Rufus Fuss

3. (b) Social Security Number: None

4. Sex: male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of ~~husband~~ or wife: Jane Edna Jones
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 22-1857 1859

8. AGE: Years: 89 Months: 2 Days: 15 If less than one day: hrs. min.

9. Birthplace: Carroll County, Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired
FATHER 12. Name: John Fuss
13. Birthplace: Maryland
MOTHER 14. Maiden name: Elizabeth Woods
15. Birthplace: Maryland
16. Informant: Paul R. Fuss
Address: Union Bridge, Md.
17. Burial, cremation, or removal, Which?: Burial Date thereof: May 9-1948 (month) (day) (year)
Cemetery or crematory: Friends Cemetery
Location: Union Bridge, Md
18. Funeral director: W. H. Hartzler & Son
Address: Union Bridge & New Windsor, Md
19. May 7 1948 (Date rec'd by registrar) W. Eckman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1948 at 6:55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to May 7 1948 and that I last saw h...ing alive on May 6. 1948

Immediate cause of death: Chronic Myocarditis — DURATION

Due to: Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Bridge Date signed: 5-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 04862

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster, route 5
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 5.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: John Henry Gesell

3.(b) Social Security Number: 218-10-4229

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Blanche E. Autz

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): September 14, 1883

8. AGE: Years	Months	Days	If less than one day
64	7	29	...hrs. ...min.

9. Birthplace: Catonsville, Md.
(Town, county, and state)

10. Usual occupation: carpenter

11. Industry or business

FATHER
12. Name: August Gesell
13. Birthplace: Holland

MOTHER
14. Maiden name: Elizabeth Zelner
15. Birthplace: Maryland

16. Informant: Blanche E. Gesell

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5/15/48 (month) (day) (year)

Cemetery or crematory: Trinity Lutheran Cem.

Location: near Smallwood, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 5/14 19 48 G. Lawrence Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 19 48 at 1½a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 48 to May 13 19 48 and that I last saw h. alive on May 13 19 48

Immediate cause of death	DURATION
Acute Cerebral Hemorrhage	2 days
Due to Chronic Hypertensive Disease	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Shuter Bar (M.D.) M. D. or other

Address: Westminster Md. Date signed 5/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04863

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 month, 29 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Avalon
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: SAMUEL ERNEST GREEN

3. (b) Social Security Number: 365-18-9854

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 5, 1892

8. AGE: Years	Months	Days	If less than one day
55	10	8	hrs. min.

9. Birthplace: Wilmington, Delaware
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Lewis Green
13. Birthplace: Wilmington, Delaware

MOTHER
14. Maiden name: Matilda Peterson
15. Birthplace: Unknown

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21 1948 (month) (day) (year)

Cemetery or crematory

Location: Gary, Indiana

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. 5/13 (Date rec'd by registrar) 19 48 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1948 at 6.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14, 1948 to May 13, 1948 and that I last saw him alive on May 13, 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben Wilson M.D. M. D. or other

Address: Henryton, Md Date signed 5/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

04864

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 723 Linnard Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Sara Mary Gumpman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	separated

6.(b) Name of husband or wife: Joseph Gumpman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 1, 1884

8. AGE: Years	Months	Days	If less than one day
63	5	3	hrs. min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: John Roberts
13. Birthplace: England

MOTHER
14. Maiden name: Margaret Cary
15. Birthplace: Ireland

16. Informant: Springfield Hospital records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/8/48 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore

18. Funeral director: George W. Little

Address: 2700 Edmondson Ave.

19. May 5 1948 C. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1948, at 12:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1948 to May 4 1948 and that I last saw her alive on May 4 1948.

	DURATION
Immediate cause of death: Generalized arteriosclerosis	?
Due to: Hypertension	?
Due to:	
Other conditions: Bronchial pneumonia	1 day

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D.
M. D. or other

Address: Sykesville, Md. Date signed: 5-4-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04865

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The date of death is especially important. Physicians: please write the causes of death clearly and legibly.

V8 A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. # 3

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel Haines Sr.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Sarah Ellen Witman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1853

8. AGE:

Years	Months	Days	If less than one day
93	8	8	..... hrs. ..... min.

9. Birthplace Frederick Co. Md.

(Town, county, and state)

10. Usual occupation Cooper

11. Industry or business

FATHER

12. Name Daniel Hainer

13. Birthplace Frd. Co. Md.

MOTHER

14. Maiden name Barbara Boston

15. Birthplace Frd. Co. Md.

16. Informant Katherine Newton

Address Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof MAY 11, 1948 (month) (day) (year)

Cemetery or crematory Mt. Zion Lutheran

Location Detour, Md.

18. Funeral director H Barnard Hoon

Address Westminster, Md.

19. 5/11 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 1948 at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1st 1947, to May 10th 1948

and that I last saw him alive on May 8th 1948

Immediate cause of death Cardio-Renal-Vascular Sclerosis

Due to Senility

Due to

Other conditions Acute suppression of urine

(Include pregnancy within 3 months of death)

DURATION
one 47 yrs.
3 days

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE V. T. Billingsley, M.D.

M. D. or other

Address Westminster Md. Date signed 5-10-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

04866

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Months, 5 Days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore - 1-
(If outside city or town limits, write RURAL and give nearest town)

Street No. 811 N. Pierce Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: FLORINE HARDY

3. (b) Social Security Number: 215- 24-7355

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col,	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1, 1926

8. AGE:

Years	Months	Days	If less than one day
21	10	9	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Robert Hardy
13. Birthplace: Virginia

MOTHER
14. Maiden name: Annie Mae Williams
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 5/13/48
(month) (day) (year)

Cemetery or crematory: mt calvary annex

Location:

16. Funeral director: A Halstead

Address: 918 Druid Hill ave

19. May 10, 19 48
(Date rec'd by registrar)

Albert R. Smallhouse
Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1948, 5:40P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5, 1948 to May 10, 1948 and that I last saw her alive on May 10, 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Oct. 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Nelson W Rowe, M. D.
M. D. or other

Address: Henryton, Md. Date signed: 5-10-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

04867

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 19 Days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 115 N. Schroeder Street

(If rural, give LOCATION)

(a) If veteran, name war:

3. (a) FULL NAME: Clementine Susie Harris

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Col	Widowed

6. (b) Name of husband or wife:

6. (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 27, 1914

8. AGE: Years: 33 | Months: 9 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md.

(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER

12. Name: Harris Thompson

13. Birthplace: Churchton, Maryland

MOTHER

14. Maiden name: Edna Thompson

15. Birthplace: Churchton, Maryland

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 24 48 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Balto Md.

18. Funeral director: Katie R. Williams

Address: 3224 Schroeder St

19. May 24 1948 (Date rec'd by registrar) Albert R. Smallhouse Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1948 at 4:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1948, to May 24 1948 and that I last saw her alive on May 24 1948.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	June 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Lowman, M.D.

M. D. or other

Address: Henryton, Maryland Date signed: 5/24/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04868

131a

Reg. Dist. No. 70

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Emma Viola Hawk

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Clarence H. Hawk
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 25, 1885

8. AGE:

Years	Months	Days	If less than one day
63	3	29	..... hrs. ..... min.

9. Birthplace: md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Wm D. Smith
13. Birthplace: md
MOTHER 14. Maiden name: Emma J. Hesson
15. Birthplace: md
16. Informant: Clarence H. Hawk
Address: Taneytown, md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 27 1948 (month) (day) (year)
Cemetery or crematory: Lutheran
Location: Taneytown, md.
18. Funeral director: Ed Dusston
Address: Taneytown Md
19. May 27, 1948 (Date filed by registrar) Ethel M. Melan Registrar

MEDICAL CERTIFICATION

E.D.S.T.

20. DATE OF DEATH May 24 1948, at 8 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1947, to May 24 1948
and that I last saw her alive on May 24 1948

Immediate cause of death	DURATION
Cardiac failure	
Due to Uremia	
Due to Chronic cardio-vascular renal disease	
Other conditions Severe hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W H Bradley M. D.
Address Taneytown, Md Date signed 5-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

0486?

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Months, 3 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore 30, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 433 W. Henrietta Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: (MANSEN) ANDERSON HEATH

3.(b) Social Security Number: 705-09-7162

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Margaret Heath
6.(c) If alive, give age: 45 years
7. Birth date of deceased (mo., day, yr.): June 14, 1900
8. AGE: Years: 47 Months: 11 Days: 2 If less than one day: hrs. min.
9. Birthplace: Chester Co., S. Carolina
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Robert Heath
13. Birthplace: Chester Co., S. Caroliaa
MOTHER 14. Maiden name: Sealie Lewis
15. Birthplace: Chester Co., S. Carolina
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/20/48 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Brooklyn, Md.
18. Funeral director: Elroy O. Wilson
Address: 1000 Beantly ave
19. May 16, 48 (Date rec'd by registrar) Albert R. Swarthout Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1948 at 8:40P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13, 1948 to May 16, 1948 and that I last saw him alive on May 16, 1948
Immediate cause of death: Pulmonary Tuberculosis — DURATION: August 1947
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 5-16-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47C / 04870

FILM No. G 116 MAY 24 1948

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 3 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severn

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Disney Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES JACKSON

3.(b) Social Security Number: 220-07-5558

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 12, 1905

8. AGE: Years: 42 | Months: 5 | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Orange County, Va. (Town, county, and state)

10. Usual occupation: Contractor

11. Industry or business

FATHER — 12. Name: William Jackson

FATHER — 13. Birthplace: Orange County, Va.

MOTHER — 14. Maiden name: Mary Brown

MOTHER — 15. Birthplace: Orange County, Va.

16. Informant: Deceased, Henryton, Md.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23 1948 (month) (day) (year)

Cemetery or crematory: St Luke's Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. 5/19 (Date rec'd by registrar) 19 48 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19, 1948 at 1.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1948 to May 19, 1948 and that I last saw him alive on May 19, 1948

	DURATION
Immediate cause of death: Bronchogenic Carcinoma	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben M. Swan, M.D. M. D. or other

Address: Henryton, Md Date signed 5/19/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

04871

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city of town limits, write RURAL and give nearest town)
How long in above place of death? 3 months 25 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 727 George Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alfred James Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Separated

6.(b) Name of hueband or wife: Mary Johnson
6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.): March 6, 1898

8. AGE: Years	Months	Days	If lese than one day
50	2	20	....hrs. ....min.

9. Birthplace: Hampton, Virginia
(Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business

FATHER
12. Name: Henry Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jennie Orange
15. Birthplace: Virginia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 27, 48 (month) (day) (year)
Cemetery or crematory Bridgeport Donghale,
Location New York City.

18. Funeral director: Geo. G. Nelson
Address 1303 Greenmount Ave.

19. May 26 19 48 (Date rec'd by registrar) Albert R. Sundheim Registrar
Local Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 19 48 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from January 31 19 48 to May 26 19 48 and that I last saw h.im alive on May 26 19 48

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide.... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D.
M. D. or other
Address Henryton, Maryland Date signed 5/26/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

180 04872

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME Horace Sylvester Johnson Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 8, 1912

8. AGE:

Years	Months	Days	If less than one day
35	4	24	hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Horace S. Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lucy Brown
15. Birthplace: Maryland

16. Informant: Horace S. Johnson
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which~~?) Date thereof 5-4-48 (month) (day) (year)
Cemetery ~~or crematory~~: Mt. Zion
Location: nr. Mt. Airy, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. May 3 1948 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1948 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation - Second and 3rd degree burns	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of May 2/48
Where did injury occur? Mt Airy Carroll Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: House burned Injured at work? No

23. SIGNATURE James T. Monk Deputy Medical Examiner
M. D. or other
Address Westminster Md Date signed May 2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b 04873

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The first name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Lowerville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. n. Warfieldsburg

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Noah Baldwin Keith

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Rena M. Keith

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7 - 1859

8. AGE:

Years	Months	Days	If less than one day
89	2	27	hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Farmer, Ret.

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace

MOTHER 14. Maiden name Not Known

15. Birthplace

16. Informant Anson R. Keith

Address Warfieldsburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7, 1948 (month) (day) (year)

Cemetery or crematory Meadow Branch Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard

Address Westminster, Md.

19. 5/6 1948 H. Bankard

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4-48 at 8.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to May 4 - 1948

and that I last saw him alive on 5-3-48

Immediate cause of death	DURATION
Myocarditis (chr)	
Hypertension (chr)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D. M. D. or other

Address Westminster Md. Date signed 5-5-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

04874

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 month, 28 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ~~Carroll~~

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 246 Bethel Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: THELMA ELIZABETH LACEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 31, 1913

8. AGE: Years: 34 Months: 9 Days: 13 If less than one day: hrs. min.

9. Birthplace: Randolph, Va. (Town, county, and state)

10. Usual occupation: Laundry Worker

11. Industry or business:

FATHER — 12. Name: Edward Lacey

13. Birthplace: Saxe, Virginia

MOTHER — 14. Maiden name: Jesse Bouldin

15. Birthplace: Randolph, Va.

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 17 1948 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cem

Location: annapolis Road.

18. Funeral director: Mrs Robert Elliott & daughter

Address: 1129 N. Caroline St.

19. 5/14 (Date rec'd by registrar) 19 48 Albert R. Swandham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 19 48 at 1.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 19 47 to May 14, 19 48 and that I last saw her alive on May 14, 19 48

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	April 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Fuman, M.D. M. D. or other

Address: Henryton, Md Date signed: 5/14/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

04875

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

18 John St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 John St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Pius Little

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Mary E. Sinnott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 3-1863

8. AGE:

Years	Months	Days	If less than one day
83	1	14	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Proprietor Laundry (Retired)

11. Industry or business

FATHER 12. Name Pius J. Little

13. Birthplace Mc. Sherrystown, Pa.

MOTHER 14. Maiden name Not known

15. Birthplace " "

16. Informant Henry E. Little

Address 18 John St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20-1948 (month) (day) (year)

Cemetery or crematory St. John Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. ✓ 17 1948 (Date rec'd by registrar) L. Hesson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th 1948 at 7:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to May 17 1948 and that I last saw h... alive on May 16 1948

	DURATION
Immediate cause of death Chronic Myocarditis	3 yrs
Due to Arteriosclerosis	30 yrs
Due to	
Other conditions Diabetes Mellitus	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. Hesson M. D. or

Address Westminster Date signed 5/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

04875

61

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 1 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 361 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1729 Guilford Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Virginia Catherine McCauley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Martin Luther McCauley (deceased) 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 17, 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	7	23		

9. Birthplace: Augusta, County, Virginia
(Town, county, and State)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Frank Taylor
13. Birthplace: Augusta County, Virginia

MOTHER
14. Maiden name: Sarah Jane Farber
15. Birthplace: Augusta County, Virginia

16. Informant: Mrs. Sarah Jane Altman
Address: 2 Pinehurst Circle, N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11, 1948 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Colmar Manor, Md.

18. Funeral director: William J. Malley

Address: 3200-R.I. Ave. Mt. Rainer, Md.

19. May 9 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1948 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1948 to May 8 1948 and that I last saw her alive on May 8 1948.

	DURATION
Immediate cause of death: Myocardial Degeneration and failure	x
Due to: Hypertensive Heart Disease	4 days
Due to: Diabetes Mellitus	undet.
Other conditions: Arteriosclerosis	11 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Morton Jacobs M.D.
M. D. or other

Address: Springfield State Hospital Date signed: 8 May

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04877 932

Reg. Dist. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster — Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred: Carroll Co. Home
How long in hospital or institution? 2 1/2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural --- Woodbine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JOHN P. MILLER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife Martha Miller deceased
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) Sept. 15, 1857

8. AGE: Years	Months	Days	If less than one day
90	8	16	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant J. Donald Miller
Address Woodbine, Md.
17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 6-2-48 (month) (day) (year)
Cemetery ~~or crematory~~ Bethel Church of God
Location Winfield, Carroll Co. Md.
18. Funeral director C. M. Waltz
Address Winfield, Md.
JUN 2 1948 19.... (Date rec'd by registrar) Ray Fogle Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1948, at 5 A: M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-10-1948, to 5-31-1948
and that I last saw ~~him~~ alive on 5-30-1948
Immediate cause of death Cardiac dijenera time DURATION 30d
Arteriosclerosis (?) years
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations No Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? No (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE W. C. Stone M. D. or other
Address Westminster Date signed 5-31-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131b

04878

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 yrs

Hospital, institution, or street address where death occurred:
68 Madison

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 68 Madison
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Noah Joseph Miller

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Lizzie P. Fowble

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Dec. 20 - 1870

8. AGE:

Years	Months	Days	If less than one day
77	5	2	....hrs. ....min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Cigar Maker

11. Industry or business

FATHER
12. Name George P. Miller
13. Birthplace Md.

MOTHER
14. Maiden name Catherine Kuney
15. Birthplace Md.

16. Informant Lizzie P. Miller

Address 68 Madison St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24-1948 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H B Bankard & Son

Address Westminster, Md.

19. 5/24/48 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22-1948, at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948 to May 22-48 and that I last saw h... alive on May 21-48

Immediate cause of death	DURATION
Myocarditis (a)	
Nephritis (b)	
Due to	
Due to	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operation Nil Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Nil Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Fennell M. D. or other

Address Westminster Md. Date signed 5-22-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Mon., 2 Days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ESTELLE MURRAY

3.(b) Social Security Number: 218-24-4618

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: William Murray

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): June 5, 1902

8. AGE: Years: 45 Months: 11 Days: 18 If less than one day: hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Factory

11. Industry or business

FATHER
12. Name: Stewart Custus
13. Birthplace: Virginia

MOTHER
14. Maiden name: Florence Purnell
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial, cremation, or removal. Which?: Burial Date thereof: 5-26-48 (month) (day) (year)

Cemetery or crematory: Baptist Woodlawn

Location: New Church, Va. (Rural)

18. Funeral director: Dennis & Watson

Address: Pocomoke City, Md.

19. (Date rec'd by registrar) May 23, 1948

Albert R. Trueblood Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23, 1948 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 1947 to May 23, 1948 and that I last saw her alive on May 23, 1948

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	March 7, 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Lowman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 5-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

180

048811

Reg. Dist. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Gloria Jean Myers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1946

8. AGE: Years 1 | Months 7 | Days 24 | If less than one day hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Harrison Myers

13. Birthplace: Maryland

MOTHER 14. Maiden name: Washola Johnson

15. Birthplace: Maryland

16. Informant: Horace S. Johnson

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 5-4-48 (month) (day) (year)

Cemetery ~~or crematory~~: Mt. Zion

Location: Nr. Mt. Airy, Md. Carroll Co.

18. Funeral director: C.M. Waltz

Address: Winfield, Md.

19. May 3 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 48 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Suffocation - Second Degree burns

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of May 2-48

Where did injury occur? Mt Airy Carroll Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury House burned Injured at work? No

23. SIGNATURE James T. Shook Reg'ly Medical Examiner
M. D. or other

Address Westminster Md Date signed May 1-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

04881

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months, 8 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore - 23-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 527 N. Mount Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MATTIE BELLE PITTMAN

3.(b) Social Security Number: 243-18-8078

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Henry Leroy Pittman
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): December 5, 1921

8. AGE: Years	Months	Days	If less than one day
26	5	6	...hrs. ...min.

9. Birthplace: Georgetown, S. Carolina
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Nathaniel Gasque
13. Birthplace: Georgetown, S. Carolina

MOTHER
14. Maiden name: Mary Trapper
15. Birthplace: Georgetown, S. Carolina

16. Informant: Deceased
Address

17. Burial Date thereof 5/14/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Ent. Calvary
Location: Brooklyn, Md.
18. Funeral director: Elroy O. Wilson
Address: 1000 Brantlyn Ave

19. May 11, 1948 Albert R. Grantham Local Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 1948 at 10:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3, 1948 to May 11, 1948 and that I last saw her alive on May 11, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1948
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Mfua, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 5-11-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of date of birth: Statement of Undertaker. 5/17/48 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

04882

Reg. Dist. No. 74

1. PLACE OF DEATH

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 5 mos. 10 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr. 5 mos. 10 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 408 Bretton Place (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME Hettie Buckingham Potter

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	M

6.(b) Name of husband or wife: Burton Wood Potter

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): Feb. 2 1874 1875

8. AGE: Years	Months	Days	If less than one day
73	3	19	hrs. min.

9. Birthplace: Md. (Town, county and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER 12. Name: John W. C. Beatty

FATHER 13. Birthplace: Pa.

MOTHER 14. Maiden name: Martha Perrin

MOTHER 15. Birthplace: Frederick Co. Md.

16. Informant: Burton Randolph Potter

Address: 408 Bretton Place Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/48 (month) (day) (year)

Cemetery or crematory: London Park

Location: Balto. Md.

18. Funeral director: Wm. J. Tickner & Sons

Address: Balto. Md.

19. 5/14 1948 A W Hedrick Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13th 1948, at 11-25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3d 1946, to May 13th 1948 and that I last saw h[illegible]ive on May 13th 1948

Immediate cause of death	DURATION
Coronary Thrombosis	?
Due to:	
Due to: Arteriosclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Hastings M.D. M. D. or other

Address: Sykesville Md. Date signed: 5/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 3-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 04883

Reg. Dist. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs. 2 months 17 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 6 yrs. 2 months 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ----

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. - - -

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME

Reaney, Charles H.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Mary A. Myers

6.(c) If alive, give age: - - - years

7. Birth date of deceased (mo., day, yr.): December 1, 1863

8. AGE: Years	Months	Days	If less than one day
84	5	26	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business: - - -

FATHER

12. Name: Alexander Reaney

13. Birthplace: Baltimore, Maryland

MOTHER

14. Maiden name: Virginia Forsythe

15. Birthplace: Baltimore, Maryland

16. Informant: Records of Springfield St. Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29 1948 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Baltimore Md.

18. Funeral director: Milton Schilling

Address: 3914 S. Hanover St.

19. May 27 1948 (Date rec'd by registrar) C. Harry Keer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1948, at 2:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947 to May 26 1948 and that I last saw him alive on May 26 1948

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	unknown
Due to: Arteriosclerosis	unknown
Due to: - - -	
Other conditions: Senile psychosis	about 10 years

(Include pregnancy within 3 months of death)

Major findings of operations: - - -

Date of op.: - - -

Autopsy results: - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: - - -

Where did injury occur? - - - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): - - -

Means of injury: - - - Injured at work? - - -

23. SIGNATURE: Martin Gross, M.D. Martin Gross, M. D. M. D. or other

Address: Sykesville, Maryland Date signed: 5/27/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04884

CERTIFICATE OF DEATH

Reg. Dist. No. 83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MAYNIE V. RIDGELY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: C.Herbert Ridgely
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): Sept. 5, 1894

8. AGE: Years	Months	Days	If less than one day
53	8	2	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Francis T. Buckingham
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ellen V. Mills
15. Birthplace: Maryland

16. Informant: Mr. C. Herbert Ridgely
Address: Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 5-10-48 (month) (day) (year)
Cemetery ~~or crematory~~: Morgan Chapel
Location: Day, Carroll Co. Maryland

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 5/10/48 (Date rec'd by registrar) Edna M. Hewett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 1948 19..., at 10:29a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1948 19... to May 7, 1948 19... and that I last saw h...er alive on May 7, 1948 19...

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 da
Due to: Malignant Hypertension	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, todustry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt. Airy, Md. Date signed 5/8/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

14886

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural, Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs. 10 mos. 16 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 34 yrs. 10 mos. 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Amelia Ritchie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John Ritchie

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): (unknown) 1878

8. AGE: Years: (64 in 1942) 70 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER
12. Name: Pearson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Hospital records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29 1948 (month) (day) (year)
Cemetery or crematory: Springfield
Location: Sykesville, Md.

18. Funeral director: Harry Weer
Address: Sykesville, Md.

19. May 28 1948 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28, 1948, at 6:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 1913 to May 28 1948 and that I last saw her alive on May 27, 1948

Immediate cause of death	DURATION
Coronary thrombosis	Few minutes
Generalized arteriosclerosis	2
Due to: Nephrosclerosis	3
Due to: Pulmonary tuberculosis	8 yrs
Other conditions: Schizophrenia, hebephrenic	35 yrs.

(Include pregnancy within 3 months of death)

Major Medical or operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Springfield State Hospital Date signed: 5/29/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04887

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 month 2 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3018 Seamon Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Cleveland Will Scott

3.(b) Social Security Number: 249-24-2411

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	Married

6.(b) Name of husband or wife: Mattie Scott

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): January 4, 1923

8. AGE: Years	Months	Days	If less than one day
25	4	4	..... hrs. ..... min.

9. Birthplace: Bishopville, S. Carolina
(Town, county, and state)

10. Usual occupation: Contractor

11. Industry or business:

FATHER
12. Name: Eli Scott
13. Birthplace: Bishopville, S.Carolina

MOTHER
14. Maiden name: Emma Eckles
15. Birthplace: Bishopville, S.Carolina

16. Informant: Deceased
Address:

17. ~~Burial~~ Shipped (Burial, cremation, or removal. Which?) Date thereof May 11, 1948 (month) (day) (year)

Cemetery or crematory: Bishop Ville

Location: Bishop Ville, S. C.

18. Funeral director: Raymond Sanders

Address: 1412 E. Preston St

19. May 8 (Date rec'd by registrar) 19 48 Albert R. Smallwood Registrar
Local Deputy

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: May 8, 19 48, at 2:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 19 47 to May 8 19 48 and that I last saw him alive on May 8 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 5/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The form is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940 04888

Reg. Dist. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Oscar David Sell

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Adah Bankert Sell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1886

8. AGE: Years	Months	Days	If less than one day
61	6	8	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Operator Bread Route

11. Industry or business

FATHER 12. Name Levi D. Sell

13. Birthplace Pa

MOTHER 14. Maiden name Flora J. Hess

15. Birthplace Md

16. Informant Mrs. Oscar D. Sell

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3, 1948 (month) (day) (year)

Cemetery or crematory Kriders

Location Westminster-Rural

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

June 2 1948 (Date rec'd by registrar) Ray Fogle Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30th 1948, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on May 30th 1948

Immediate cause of death	DURATION
Disease of Coronary Arteries	Few moments
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Billingslea, M. D. M. D. or other

Address Westminster, Md. Date signed 6-2-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

472

U4881

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster # 7
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. 7
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Earl Francis Sentz

3.(b) Social Security Number 218-10-4402

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Nellie V. Fox
6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) April 22 - 1892

8. AGE: Years	Months	Days	If less than one day
56	—	13	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business
FATHER 12. Name Amos Sentz
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Mary E. Barnes
15. Birthplace Carroll Co. Md.
16. Informant Nellie V. Sentz
Address Westminster R.D. 7. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18-1948 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster Md.
18. Funeral director H. Bankard Son
Address Westminster, Md.
19. 5/17 1948 H. Bankard
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 - 1948 at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to May 16 1948 and that I last saw h.. alive on May 16 - 1948

Immediate cause of death	DURATION
Cancer lung	11 mo.
Nephritis (chr)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D. M. D. or other
Address Westminster Md Date signed 5-17-48

FS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04890

74

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
Maryland Tbc. Sanatorium
Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2047 Llewllyn Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Branch Smith

3.(b) Social Security Number: 213-16-3865

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1896

8. AGE:

Years	Months	Days	If less than one day
51	4	26	hrs. min.

9. Birthplace: Roanoke, Va. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Sidney Smith

13. Birthplace: Va.

MOTHER

14. Maiden name: Bettie Scott

15. Birthplace: Va.

16. Informant: deseased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 26, 1948 (month) (day) (year)

Cemetery or crematory: U.S. National Cemetery

Location: Baltimore, Md.

18. Funeral director: Robert E. Williams

Address: 1515 McElderry St

19. 5-21-48 (Date rec'd by registrar) 19 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21, 1948, 19, at 2:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11th. 1948 to May 21st 1948

and that I last saw him alive on May 21, 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1948

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben A. Ofman M.D.

M.D. or other

Address: Henryton, Md. Date signed: 5-21-48


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MAY 24 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04891

CERTIFICATE OF DEATH

Reg. Dist. No. 8d

1. PLACE OF DEATH:
County: Carroll
City or town: Medford
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Medford
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Wilbur Smith

3.(b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Julia Gerber
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): October 23 - 1903
8. AGE: Years: 44 Months: 6 Days: 8 If less than one day: hrs. min.
9. Birthplace: Frederick County, Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm
FATHER 12. Name: not known
13. Birthplace: Virginia
MOTHER 14. Maiden name: not known
15. Birthplace: Virginia
16. Informant: Julia E. Smith
Address: Medford, Md
17. (Burial, cremation, or removal. Which?) Burial Date thereof: 5 (month) 4 (day) 48 (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: Uniontown Road
18. Funeral director: H. H. Hartsock & Son
Address: Union Bridge & New Windsor Rd
19. May 3 1948 (Date rec'd by registrar) Ernest G. Benedict Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1948 at 10:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Coronary occlusion	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Shard Deputy Medical Examiner
M. D. or other
Address: Westminster Md Date signed: May 1-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04892

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? years

Hospital, institution, or street address where death occurred: 118 Pennsylvania Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 110 Pennsylvania Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Jacob Stonesifer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	M

6.(b) Name of husband or wife: Emma

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 21, 1884

8. AGE: Years	Months	Days	If less than one day
63	4	16	hrs. min.

9. Birthplace: York County, Penna. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Green House

FATHER — 12. Name: Wm Stonesifer

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Rebecca Strickler

MOTHER — 15. Birthplace: Md Va

16. Informant: Mrs. Stonesifer

Address: Westminster

17. (Burial, cremation, or removal. Which?) Burial Date thereof 5-24-48 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Hanover, Pa

18. Funeral director: H. Bernard Yohn

Address: Westminster, Md.

19. (Date rec'd by registrar) 5/18/48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 19 48 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Coronary Occlusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: James T. Marker Dept. Med. Examiner M. D. or other

Address: Westminster, Md. Date signed 5/18/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04893

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore 1,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 830 Bradley Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JESSIE ALEXANDER STRAITEN

3.(b) Social Security Number: 219-05-8195

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Hattie Straiten
6.(c) If alive, give age: 29 years
7. Birth date of deceased (mo., day, yr.): December 11, 1909
8. AGE: Years: 38 Months: 5 Days: 7 If less than one day: hrs. min.
9. Birthplace: Calvert County, Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Joseph F. Straiten
13. Birthplace: Calvert Co., Maryland
MOTHER 14. Maiden name: Frances Brown
15. Birthplace: Calvert Co., Maryland
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/18/48 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cem
Location: Mt Vernon
18. Funeral director: Chas H. Alexander
Address: 1200 McCulloh St
19. May 18, 19 48 (Date rec'd by registrar) Albert R. Swankhaus Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18, 19 48 at 4:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 19 48 to May 18, 19 48 and that I last saw him alive on May 18, 19 48
Immediate cause of death: Pulmonary Tuberculosis — DURATION: December 1947
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed 5-18-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

04894

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Libertytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MARCULLUS WEBSTER SWEADNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 5, 1877

8. AGE: Years: 70 | Months: 6 | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick County, Maryland
(Town, county, and state)

10. Usual occupation: Bricklayer

11. Industry or business

FATHER
12. Name: William Sweadner
13. Birthplace: Frederick County

MOTHER
14. Maiden name: Frances Slifer
15. Birthplace: Frederick County

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10, 1948 (mo.) (day) (year)
Cemetery or crematory: Fairmount
Location: Libertytown, Md.

18. Funeral director: Powell & Hartzler
Address: Woodsboro, Md.

19. May 10 19 48 Harry Keefer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1948 at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 1948, to May 8, 1948 and that I last saw him alive on May 8, 1948

	DURATION
Immediate cause of death: Cerebral Accident	3 days
Due to: Generalized arteriosclerosis	1 yr.
Due to: Terminal bronchopneumonia	2 days
Other conditions: Psychosis with cerebral arteriosclerosis	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Sykesville, Maryland Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:

County ....

City or town ....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ....

Hospital, institution, or street address where death occurred: ....

How long in hospital or institution? ....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State .... County ....

City or town ....
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war ....

3. (a) FULL NAME ....

3. (b) Social Security Number ....

4. Sex ...... 5. Color or race ...... 6.(a) Single, married, widowed, or divorced ......

6.(b) Name of husband or wife ....

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) ....

8. AGE: Years	Months	Days	If less than one day
			.... hrs. .... min.

9. Birthplace ....
(Town, county, and state)

10. Usual occupation ....

11. Industry or business ....

FATHER 12. Name ....

13. Birthplace ....

MOTHER 14. Maiden name ....

15. Birthplace ....

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BUREAU V. S.

16. Informant ....

Address ....

17. (Burial, cremation, or removal. Which?) .... Date thereof .... (month) (day) (year)

Cemetery or crematory ....

Location ....

18. Funeral director ....

Address ....

19. (Date rec'd by registrar) .... 19...... .... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH .... 19...... at .... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19....

and that I last saw h...... alive on .... 19....

	DURATION
Immediate cause of death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....

Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work? ....

23. SIGNATURE .... M. D. or other

Address .... Date signed ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct statement of the causes of death is especially important. Physicians please write legibly.

MARGIN RESERVED FOR BINDING

VS AIS M-15-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 13b 04895

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 17 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 8 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 810 W. Fayette Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frank Anthony Verderami

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 13, 1904

8. AGE: Years	Months	Days	If less than one day
43	11	2	..... hrs. ..... min.

9. Birthplace: Baltimore City

(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: ✓

FATHER

12. Name: Simon Verderami

13. Birthplace: Italy

MOTHER

14. Maiden name: Rosa ~~Remaldio~~ Remaldio

15. Birthplace: Italy

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/18/48 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem

Location: #300 Old Frederick Road

18. Funeral director: Dolle & Conway & Son

Address: 901-03 Hollins St

19. 5/12/48 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 19 48 at 11:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 19 47 to May 15 19 48 and that I last saw him alive on May 15 19 48

Immediate cause of death: Active tuberculosis of the lungs. — DURATION: 8 mos.

Due to: .....

Due to: .....

Other conditions: Schizophrenia, hebephrenic type.

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Ilse Kamm, M.D. M. D. or other

Springfield State Hospital

Address: Sykesville, Maryland Date signed 5-15-48

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04896

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Months, 5 Days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Harve-de-Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 412 Freedom Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: RACHEL ELIZABETH WALKER (WADE)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 1, 1920

8. AGE: Years: 27 Months: 9 Days: 13 If less than one day: hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER
12. Name: John Walker
13. Birthplace: W. Virginia

MOTHER
14. Maiden name: Virginia Dennis
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17 1948 (month) (day) (year)
Cemetery or crematory: St James
Location: Havre de Grace Md.

18. Funeral director: E. Madison Mitchell
Address: Havre de Grace Md.

19. May 14, 1948 (Date rec'd by registrar) Albert R. Smyth Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 1948, at 2:45A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 10, 1948, to May 14, 1948 and that I last saw her alive on May 14, 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Offutt M. D. (M. D. or other)

Address: Henryton, Md. Date signed: May 14, 1948

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

55-2

04897

Reg. Dist. No. 76

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Rural, Near Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Westminst

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Uniontown Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME (Starehime)

Deuton Wilmer Warehime

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	widowed

8.(b) Name of husband or wife: M. Elizabeth Warehime

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 29. 1873

8. AGE:

Years	Months	Days	If less than one day
75	1	13	..... hrs. ..... min.

9. Birthplace: Uniontown Road Westminster (Town, county, and state) Carroll Co. Md

10. Usual occupation: Carpenter

11. Industry or business

FATHER

12. Name: David H. Warehime

13. Birthplace: Carroll Co. Md.

MOTHER

14. Maiden name: Sarah Reble

15. Birthplace: Carroll Co. Md.

16. Informant: Roger Warehime

Address: Westminster R. D Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15 48 (month) (day) (year)

Cemetery or crematory: Reisters Cemetery

Location: Near Westminster Md.

18. Funeral director: J. E. Myers Jr.

Address: Westminster Md.

19. 5/14 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1948, at 10:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948, to May 12 1948

and that I last saw him alive on May 12 1948

Immediate cause of death	DURATION
Carcinoma Left Forearm	4 mo
Due to: Squamous cell Carcinoma	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. Glenn Roeder M. D. or other

Address: Westminster Md. Date signed: 5/14/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04898

94a

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Leanmell

City or town: Rural Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mon -

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Leanmell

City or town: Rural - Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Theodore Warner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Mary (Kessebing) Rabrbaugh 6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): March - 29 - 1868

8. AGE:

Years	Months	Days	If less than one day
80	1	29	... hrs. ... min.

9. Birthplace: York County, PA. (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: Retired Farming

FATHER

12. Name: Henry Warner

13. Birthplace: York County, PA.

MOTHER

14. Maiden name: Arabella (Wearner) Warner

15. Birthplace: York County, PA

16. Informant: Edward Warner

Address: Taneytown, Md. R.D. 1

17. Removal for Burial (Burial, cremation, or removal. Which?) Date thereof May - 31 - 1948 (month) (day) (year)

Cemetery or crematory: Shaeffers Cemetery

Location: York County, PA.

18. Funeral director: J. M. Little & Son

Address: Littlestown, PA. Rep R. A Little

19. May 28 1948 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 1948 at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary Artery disease — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: James T. Thorn Deputy Medical Examiner M. D. or other

Address: Baltimore Md Date signed 5/28/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7K

14885

93d

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: - - -
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2038 Braddish Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: - - -

3.(a) FULL NAME: Ridinger, Robert Wesley

3.(b) Social Security Number: 216-01-6554 A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Blanche E. Ridinger

6.(c) If alive, give age: unkn years

7. Birth date of deceased (mo., day, yr.): October 25, 1874

8. AGE: Years	Months	Days	If less than one day
73	6	18	...hrs. ...min.

9. Birthplace: Baltimore [illegible], Maryland
(Town, county, and state)

10. Usual occupation: bricklayer

11. Industry or business: - - -

FATHER
12. Name: John Thomas Ridinger
13. Birthplace: Maryland, Taneytown.

MOTHER
14. Maiden name: Amelia Null
15. Birthplace: Maryland

16. Informant: ~~Records of Springfield St. Hospital~~ wife
Address: ~~Sykesville, Maryland~~ 2038 Braddish Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/17/48 (month) (day) (year)
Cemetery or crematory: St. James
Location: Carroll Co, Md.

18. Funeral director: Wm. H. Tickner & Sons
Address: Balto, Md.

19. 5/14 19 48 A.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1948 at 10:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1948 to May 12 1948 and that I last saw him alive on May 12 1948

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	more than 2 months.
Due to: - - -	
Due to: - - -	
Other conditions: Arteriosclerosis	unknown
Senile psychosis, delirious, confused - 5 yrs. type (Include pregnancy within 3 months of death)	

Major findings of operations: - - -
Date of op.: - - -
Autopsy results: - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Martin Gross, M. D. M. D. or other
Address: Sykesville, Maryland Date signed: 5/13/48

Martin Gross, M.D.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

04893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos. 1 day
Hospital, institution, or street address where death occurred: Maryland Tbc. Sanatorium, Col. Branch
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Sommerset
City or town: Princess Anne
(If outside city or town limits, write RURAL and give nearest town)
Street No. 257 Bedford Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cardrena White

3.(b) Social Security Number: 219-07-1116

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1912

8. AGE: Years: 36 | Months: 3 | Days: 23 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Princess Anne, Md., Sommerset Co.
(Town, county, and state)

10. Usual occupation: Factory

11. Industry or business

FATHER
12. Name: Will White
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emma Deshields
15. Birthplace: Maryland

16. Informant: deseased
Address

17. Burial (Burial, cremation, or removal) Which?) Date thereof 5/23/48 (month) (day) (year)
Cemetery or crematory: Princess Anne Cemetery
Location: Princess Anne Md.

18. Funeral director: Chas. G. Corbin
Address: 510-12 Cantelou Ave.

19. May 20, 1948 Albert R. Swarthout
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1948 at 9:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19, 1947 to May 20, 1948 and that I last saw her alive on May 20, 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Ruben Hoffman M.D.
M. D. or other
Address: Henryton Md. Date signed: 5-20-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 8 month 9 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1004 Lexington Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Inez Wooded

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Married

6.(b) Name of husband or wife: Oscar Wooded

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 20, 1914

8. AGE: Years: 33 Months: 6 Days: 19 If less than one day: hrs. min.

9. Birthplace: Wells, N. Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Gilbert Johnson

13. Birthplace: Unkonwn

MOTHER — 14. Maiden name: Minnie Golds

15. Birthplace: Unknown

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/13/48 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cem.

Location: Balto. Md.

18. Funeral director: Wm. Pate & Williams

Address: 322 N. Schroeder St

19. May 9 1948 (Date rec'd by registrar) Albert R. Sumwalt Local Deputy Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: May 9 1948 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1946 to May 9 1948 and that I last saw her alive on May 9 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 5/9/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 26 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1612 Mc Culloh Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

William Nathan Wyatt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 5, 1912

8. AGE: Years	Months	Days	If less than one day
35	5	24	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER 12. Name: Thomas Wyatt

13. Birthplace: Virginia

MOTHER 14. Maiden name: Malinda Wheeler

15. Birthplace: Baltimore, Maryland

16. Informant: William Nathan Wyatt

Address: 1612 McCulloh St. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4 (month) (day) 1948 (year)

Cemetery or crematory: Mt. Auburn Cemetery

Location: Balto. Md.

18. Funeral director: Mrs. Ewd. H. Hall

Address: 1631 Druid Hill Ave.

19. May 29 (Date rec'd by registrar) 1948 Albert R. Swanson Local Deputy Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: May 29 19 48 at 8:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 19 48 to May 29 19 48 and that I last saw him alive on May 29 19 48

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Aug. 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Nelson D. Swan, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 5/29/48